

DEPARTMENT OF THE MEDICAL EXAMINER

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POWERS, DUTIES AND FUNCTIONS

The Department of the Medical Examiner serves the public through the investigation of sudden, unexpected, violent and suspicious deaths. The purpose of such an investigation is to discover, document and preserve the medical, anatomic or evidentiary findings which will allow the department to determine the cause and manner of death, to identify the time of death and injury, to prove or disprove an individual's guilt or innocence, to confirm or deny the account of how death occurred, to determine or exclude other contributory or causative factors to the death and to provide expert testimony in criminal and civil litigation.

Section 6-1305 of the 1973 Revised Charter of the City and County of Honolulu (2000 Edition) states, "When any person dies in the city as a result of violence or by a casualty or by apparent suicide or suddenly when in apparent health or when not under the care of a physician or when in jail or in prison or within twenty-four hours after admission to a hospital or in any suspicious or unusual manner, it shall be the duty of the person having knowledge of such death immediately to notify the department of the medical examiner and the police department."

The Department of the Medical Examiner is staffed by physicians specialized in the area of forensic pathology, medical examiner's investigators, laboratory technologists, autopsy assistants and clerical personnel. The physicians are board certified in the specialty of anatomic pathology as required and stated in Section 841-14.5 of the Hawaii Revised Statutes. The chief medical examiner and deputy medical examiner are board certified by the American Board of Pathology in anatomic, clinical and forensic pathology.

The department is accredited by the National Association of Medical Examiners (NAME). Accreditation by NAME is an endorsement that the department provides an adequate environment for a medical examiner in which to practice and provides reasonable assurance that the department well serves its jurisdiction. It is the objective of NAME that the application of the NAME standards will aid materially in developing and maintaining a high caliber of medicolegal investigation of death for the communities and jurisdictions in which they operate.



Dr. De Alwis conducts educational seminar

The staff is aware of the tragedy that accompanies sudden and unexpected deaths and realizes that each case represents an individual who is deeply missed by his or her loved ones. Our investigators are trained to deliver the news of the death with the utmost compassion, courtesy and professionalism. A thorough investigation into the circumstances of death, complete postmortem examination and necessary laboratory studies are conducted to determine the cause and manner of death. In addition to providing pertinent answers for significant issues such as insurance claims, estate settlements, information and evidence necessary for civil and criminal legal proceedings, we also provide factual data for relatives which helps them through their grieving process with better understanding of the cause and

manner of death. The physicians are available for the relatives, attorneys and estate representatives to provide necessary information.

HIGHLIGHTS



Prosecutors examine digital x-ray

One of the main objectives of the department is to protect the public health of the citizens of Oahu by (a) diagnosing previously unsuspected contagious disease, (b) identifying trends affecting the lives of our citizens such as drug-related deaths, teen suicides, etc., and (c) to identify hazardous environmental conditions in the workplace, home and elsewhere. Educational seminars with emphasis on child abuse, identification of risk factors of sudden unexplained infant deaths are conducted for law enforcement personnel, social workers of the Child Protective Services, and physicians. Educational seminars have been conducted with emphasis on prevention of elderly

neglect/abuse to increase the public awareness in identification, intervention, and treatment for elders and their caregivers. Prevention of deaths through morgue tours for high school students are conducted with an informative presentation on drug-related deaths, speeding accidents, teen suicides, and other trends affecting the lives of our citizens, to provide a better perspective of how their actions and decisions can affect them as well as everyone else around them. The department participates in the multi-disciplinary Child Death Review System. Recommendations for decreasing the number of child deaths following an adequate interval study will be provided. Renewed emphasis has been and will continue to be placed on assisting local donor agencies to obtain consent for organ and tissue procurement. The department continues to participate in the Honolulu Heart Program that has been expanded to include aging studies of the brain in pre-registered participants. Scientific death investigation provides factual material and evidence for agencies involved in worker's compensation, public health hazards and community health and disease.

The department offers pathology electives to medical students, medical transitional program residents, and pathology residents from the University of Hawaii John A. Burns School of Medicine. In addition, students majoring in forensic science at Chaminade University are given an opportunity to do an internship as part of their requirement to complete their Forensic Science bachelor's degree.

The department maintains a high level of competence in the field of scientific death investigation and continues to contribute to the improvement of the quality of life of the people of Oahu.

The work of the department is tabulated in statistical form as follows:

SUMMARY OF STATISTICAL REPORT OF CASES HANDLED BY DEPARTMENT, 2006-2007

The office investigated 1894 deaths this past year as compared to 1813 in 2005-2006. Jurisdiction was assumed in 750 cases and autopsies were performed in 555 cases. In non-autopsied cases, complete external examinations and toxicological testing of body fluids were performed.

Authorization for organ harvesting was permitted on 15 cases. Of the 750 cases investigated, 357 death scenes were visited. These scenes are where the incident occurred and, therefore, are an integral part of a thorough death investigation. For example, if a death of a young child occurs in a medical institution, in addition to visiting the medical institution, our medical examiner's investigator goes to the original scene of the incident.

Number of deaths investigated 1894

..... Jurisdiction assumed in750

..... Violent deaths472

..... Autopsied 374

..... Not autopsied 98

..... Violent deaths (undetermined manner) 26

..... Autopsied 25

..... Not autopsied 1

..... Non-violent deaths250

..... Autopsied 155

..... Not autopsied 95

..... Historical remains... 0

..... Non-human artifacts..... 0

..... Human remains..... 2

..... Jurisdiction released to private physician

..... (death within 24 hours).....789

..... Attended/other deaths reported355

Total autopsies performed by Medical Examiner..... 555

Total number of bodies transported to Morgue.. 737

Total organ/tissue harvesting..... 15

Total original scene of incident visited 357

Total unidentified skeletal remains 0

LABORATORY PROCEDURES CONDUCTED DURING FISCAL YEAR 2006-2007

Laboratory Chemical Tests	850
Ethanol Tests.....	750
Toxicology Screen	1500
Toxicology Sent Out	301
Hematoxylin and Eosin Slides Prepared.	2959
Special Slides Prepared	53

Laboratory procedures that include toxicological analysis, blood alcohol determinations, preparation of microscopic slides for histological examinations and various other chemical analyses of different types of body fluids, continue to be a very important aspect of investigation of deaths occurring under our jurisdiction.

There have been an increased number of drug-related deaths. There is concern with regard to the rise in the number of deaths associated with methadone. Cocaine, opiates, Oxycontin and methamphetamine continue to be detected in toxicological screens of deaths investigated by the Department. Methamphetamine continues to be associated with violent deaths.

REQUEST FOR REPORTS FISCAL YEAR 2006-2007

Investigation and Autopsy Reports	809
..... Fees Collected	\$3,801.00

A fee of \$5.00 is charged for each report requested by individuals and private agencies. There is no charge to governmental agencies or to hospitals. There is a fee of not less than \$5.00 for reports subpoenaed.

BUDGET AND AUTHORIZED PERSONNEL FISCAL YEAR 2006-2007

Budget Expenditures	\$1,351,572.22
..... Salaries	\$1,052,448.55
..... Current Expenses ..	287,812.38
..... Equipment...	11,311.29
..... Positions.....	18

CLASSIFICATION OF VIOLENT DEATHS FISCAL YEAR 2006-2007

The number of violent deaths increased slightly. There were 212 other accidental deaths this past year compared to 180 in 2005-2006. Falls (94) and poisoning (89) comprised the majority of the 212 victims. Significant increase in the male (70) to female (17) ratio of suicide victims is noteworthy.

..... Violent Deaths..... 509
..... Homicide	27
..... Asphyxia.....	2
..... Blunt trauma	4
..... Child abuse	3
..... Fall.....	1
..... Gunshot.....	9
..... Knife wounds/stabbing	5
..... Sharp force trauma.	1
..... Other	2
..... Suicide	87
..... Asphyxia.....	3
..... Drowning	2
..... Fall.....	19
..... Fire	1
..... Gunshot.....	12
..... Hanging	41
..... Poisoning.....	7
..... Sharp force trauma.	2
..... Traffic	92
..... Water-Related	38
..... Industrial.....	9
..... Other Accident	212
..... Undetermined.....	44
..... Drowning	2
..... Fall.....	7
..... Hanging	1
..... Poisoning.....	16
..... Unknown	17
..... Other	1

NOTE: Some deaths are reported in 2 different categories.

**BREAKDOWN OF HOMICIDE VICTIMS BY RACE
FISCAL YEAR 2006-2007**

<u>Race</u>	<u>2006 July-December</u>	<u>2007 January-June</u>	<u>Total</u>
Caucasian	0	6	6
Chinese	0	1	1
Filipino	2	1	3
Hawn/Part-Hawn	4	3	7
Japanese	3	1	4
Samoan	1	0	1
All Other	3	2	5
TOTAL	13	14	27

**BREAKDOWN OF HOMICIDE METHODS USED
FISCAL YEAR 2006-2007**

<u>Methods Used</u>	<u>2006 July-December</u>	<u>2007 January-June</u>	<u>Total</u>
Asphyxia	0	2	2
Blunt trauma	1	3	4
Child Abuse	2	1	3
Fall	1	0	1
Gunshot	5	4	9
Knife wounds/ Stabbing	1	4	5
Sharp force trauma	1	0	1
Other	2	0	2
TOTAL	13	14	27

**SUICIDE STATISTICS
FISCAL YEAR 2006-2007**

<u>Method</u>	<u>Cau</u> <u>M</u> <u>F</u>	<u>Chi</u> <u>M</u> <u>F</u>	<u>Fil</u> <u>M</u> <u>F</u>	<u>Hawn</u> <u>P-Hawn</u> <u>M</u> <u>F</u>	<u>Jps</u> <u>M</u> <u>F</u>	<u>Kor</u> <u>M</u> <u>F</u>	<u>Oth</u> <u>M</u> <u>F</u>	<u>Total</u>
Asphyxia	1		1				1	3
Drowning		1				1		2
Fall	6 2	1 2		2	1 2	1	2	19
Fire	1							1
Gunshot	5		2	1	1		3	12
Hanging	6	1	4	8 3	6 3	2	7 1	41
Sharp Force Trauma					1 1			2
Poisoning	2			1		1	3	7
TOTAL	21 2	3 2	7 0	11 4	9 6	3 2	16 1	87

**SUICIDE VICTIMS
FISCAL YEAR 2006-2007**

<u>Age</u>	<u>Male</u>	<u>Female</u>	<u>Total</u>
10 thru 19	5	0	5
20 thru 29	11	6	17
30 thru 39	16	1	17
40 thru 49	17	2	19
50 thru 59	9	5	14
Over 60	12	3	15
TOTAL	70	17	87

**SUMMARY OF SUICIDES
FISCAL YEAR 2006-2007**

<u>2006</u>	<u>Male</u>	<u>Female</u>	<u>Total</u>
July	9	1	10
August	4	2	6
September	5	1	6
October	3	0	3
November	5	1	6
December	4	2	6
Sub-Total	30	7	37
<u>2007</u>			
January	6	0	6
February	7	1	8
March	7	2	9
April	6	2	8
May	8	3	11
June	6	2	8
Sub-Total	40	10	50
TOTAL	70	17	87

**TRAFFIC FATALITIES
FISCAL YEAR 2006-2007**

<u>Type of Occupant</u>	<u>MALE</u>			<u>FEMALE</u>			<u>Total</u>
	<u>2006 July-Dec</u>	<u>2007 Jan-Jun</u>	<u>With Alc.</u>	<u>2006 July-Dec</u>	<u>2007 Jan-Jun</u>	<u>With Alc.</u>	
Operator	9	11	8	5	3	2	28
Passenger	5	6	5	4	3	2	18
Pedestrian	6	7	3	4	9	0	26
Motorcyclist	6	7	2	0	0	0	13
Moped Rider	5	0	0	0	0	0	5
Bicyclist	2	0	0	0	0	0	2
TOTAL	33	31	18	13	15	4	92

WATER-RELATED DEATHS
FISCAL YEAR 2006-2007

There were 38 water-related deaths compared to 46 last year. Twenty-four victims died while engaged in ocean-related activities, in comparison to 30 last year.

<u>Location and Activity</u>	<u>MALE</u>		<u>FEMALE</u>		<u>Total</u>
	<u>2006 July-Dec</u>	<u>2007 Jan-Jun</u>	<u>2006 July-Dec</u>	<u>2007 Jan-Jun</u>	
Ocean					
Body Boarding	2	0	0	1	3
Diving	1	1	0	0	2
Fishing	2	2	0	0	4
Kayak	1	0	0	0	1
Snorkeling	3	1	0	0	4
Surfing	0	1	0	0	1
Swimming	6	2	1	0	9
Bay/Harbor/Lagoon/Pier	0	0	2	0	2
Pond/Canal/Lake/Stream	1	1	0	1	3
Swimming Pool	0	3	0	1	4
Bathtub	0	1	0	1	2
Other	2	0	0	1	3
TOTAL	18	12	3	5	38

**INDUSTRIAL DEATHS
FISCAL YEAR 2006-2007**

There were nine job-related deaths this year compared to two the previous year.

<u>Age</u>	<u>Synopsis</u>
53	Tree trimmer sustained multiple blunt force injuries when the limb of a tree he was cutting fell on him.
56	Truck driver sustained crush injuries when a load of bearings toppled from a forklift.
50	Postal carrier sustained craniocerebral injuries when she lost control of her postal vehicle and struck a lamp post.
30	Solo bike officer sustained complications of blunt force injuries during a Presidential escort when he was ejected from his motorcycle.
27	Bartender sustained gunshot wound injuries when he attempted to disarm a person with a handgun.
23	Deck hand drowned while securing a catamaran line to a submerged anchored buoy.
52	Iron worker sustained multiple internal injuries at a job site when he fell from the 46 th floor while caulking the lanai.
40	Landfill supervisor sustained sepsis due to thermal burns at a job site when he fell into a flow of hot ash.
24	Laborer sustained multiple crush injuries at a job site when he was pinned under an overturned truck he was operating.

**OTHER ACCIDENTAL DEATHS
FISCAL YEAR 2006-2007**

<u>Method</u>	<u>MALE</u>		<u>FEMALE</u>		<u>Total</u>
	<u>2006 July-Dec</u>	<u>2007 Jan-Jun</u>	<u>2006 July-Dec</u>	<u>2007 Jan-Jun</u>	
Asphyxia	1	4	2	0	7
Blunt Trauma	1	2	1	0	4
Fall	23	30	21	20	94
Fire	1	1	1	0	3
Poisoning	32	37	12	8	89
Other	3	8	0	4	15
TOTAL	61	82	37	32	212

UNDETERMINED DEATHS (MANNER)
FISCAL YEAR 2006-2007

When investigative information and autopsy findings cannot determine the fashion in which a cause of death came about, the manner of death is listed as "Undetermined". Forty-four deaths fell within this category. The majority of cases fell into two categories, poisoning (drug-related) where accidental or intentional overdose could not be determined and unknown where after complete autopsy, the cause and manner of death could not be determined.

<u>Method/Cause</u>	<u>MALE</u>		<u>FEMALE</u>		<u>Total</u>
	<u>2006 July-Dec</u>	<u>2007 Jan-June</u>	<u>2006 July-Dec</u>	<u>2007 Jan-June</u>	
Drowning	0	0	2	0	2
Fall	1	1	4	1	7
Hanging	0	1	0	0	1
Poisoning	6	3	2	5	16
Unknown	2	4	6	5	17
Other	0	0	1	0	1
TOTAL	9	9	15	11	44